Nos. 93-1662, 93-1663, 93-1664

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

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OFFICE OF THE CLERK

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(Caption continued on inside front cover)

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD

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61 pp

MARIO M. CUOMO, ET AL.,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* (1988 & Supp. IV 1992), preempts portions of New York's comprehensive hospital rate-setting and insurance regulatory scheme, which do not refer to and are not predicated upon the existence of ERISA plans, do not single out ERISA plans for special treatment and do not dictate choices regarding benefits or plan structure, but which may have an indirect economic impact upon such plans?

2. Whether the challenged statutes are saved from preemption as laws regulating insurance within the meaning of ERISA's saving clause?

PARTIES TO THE PROCEEDING

The parties to the proceeding below were: **Petitioners** Mario M. Cuomo, in his official capacity as Governor of the State of New York, Mark Chassin, M.D., in his official capacity as Commissioner of Health for the State of New York, Salvatore R. Curiale, in his official capacity as Superintendent of Insurance of the State of New York, Michael J. Dowling, in his official capacity as Commissioner of Social Services of the State of New York, Robert Abrams, in his official capacity as Attorney General of the State of New York, New York State Conference of Blue Cross & Blue Shield Plans, Empire Blue Cross and Blue Shield, and The Hospital Association of New York State; and **Respondents** The Travelers Insurance Company, Health Insurance Association of America, American Council of Life Insurance, Life Insurance Council of New York, Inc., Aetna Life Insurance Co., Aetna Health Plans of New York, Inc., Mutual of Omaha Insurance Company, Union Labor Life Insurance Company, Professional Insurance Agents of New York, Inc. Trust, New York State Health Maintenance Organization Conference and Health Services Medical Corporation, MVP Health Plan, Wellcare of New York, Mid-Hudson Health Plan, Oxford Health Plan, Capital District Physicians Health Plan, Choicecare Long Island, Independent Health, Travelers of New York, Physicians Health Services, Preferred Care, and U.S. Healthcare.*

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* References to the Appendix to the Petitions for a Writ of Certiorari are referred to as "A- __". References to the Joint Appendix are referred to as "JA- __".

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

Nos. 93-1408, 93-1414, 93-1415

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

MARIO M. CUOMO, ET AL.,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

—v.—

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD

The New York State Conference of Blue Cross and Blue Shield Plans (the "Plans")[1] and Empire Blue Cross and Blue Shield ("Empire")[2] respectfully submit this brief requesting this Court to reverse the ruling by the Second Circuit Court of Appeals that ERISA preempts portions of New York Public Health Law § 2807-c (McKinney 1993), which prescribe the rate hospitals must charge particular classes of payors for inpatient hospital services.

OPINIONS BELOW

The January 14, 1994 amended opinion of the Court of Appeals for the Second Circuit is officially reported at 14 F.3d 708 (2d Cir. 1994) and reprinted in its entirety at A-1-34 and JA-30-65.[3] The February 3, 1993 Opinion and Order of

[1] The Plans are: Empire Blue Cross and Blue Shield; Blue Cross and Blue Shield of Utica-Watertown, Inc.; Blue Cross and Blue Shield of Central New York, Inc.; Finger Lakes Health Insurance Co., Inc.; Finger Lakes Medical Insurance Co., Inc. (dba Blue Cross and Blue Shield of the Rochester Area); and Blue Cross and Blue Shield of Western New York, Inc. (JA-215.)

[2] Each of the Plans, including Empire, is a not-for-profit corporation operating in accordance with Article 43 of the New York State Insurance Law. As such, they do not have parent companies, subsidiaries or affiliates of the type subject to Rule 29.1.

[3] The original opinion of the Second Circuit Court of Appeals, dated October 25, 1993, is unofficially reported at 62 U.S.L.W. 2290 (2d Cir. Oct. 25, 1993). (A-35-62.) The original opinion and the amended opinion (issued after the Second Circuit granted rehearing) are identical except for the discussion of preemption under the Federal Employee Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.* (1988 & Supp. IV 1992). The issue of FEHBA preemption is not before this Court.

the United States District Court for the Southern District of New York is officially reported at 813 F. Supp. 996 (S.D.N.Y. 1993) and reprinted in its entirety at A-63-90.

JURISDICTION

The petition for a writ of certiorari was filed on March 9, 1994 and was granted on October 7, 1994. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1988).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

The relevant provisions of ERISA's preemption provision, 29 U.S.C. § 1144(a) (1988), are reprinted at A-99-100. The relevant provisions of N.Y. Pub. Health Law § 2807-c (McKinney 1993) are reprinted at A-101-113.

STATEMENT OF THE CASE

For over ten years, New York State has regulated hospital rates in a manner that not only controls costs but also uses that control to effectuate specific insurance objectives. The difference between what the Plans pay for inpatient hospital care and what plaintiffs pay—the "differential"—assists the Plans in shouldering the burden of open enrollment for individuals and small groups (that is insuring all applicants without regard to age, occupation or physical condition) on a community rated basis as well as other publicly responsible activities. The differential was enacted into statute in 1983, but codified a decades old difference in the hospital rates paid by the Plans as compared to other payors. (JA-161-62, 179-82, 218-23.)

The differentials apply generally to categories of payors for hospital services without regard to whether the payor's customer is an ERISA plan. They do not refer to or operate with

regard to the existence of ERISA plans. Nor do they dictate or restrict the choices plans can make regarding benefits to be provided or their administration. At most, they may indirectly impact the cost to an ERISA plan—like countless other state laws—of purchasing hospital benefits for its participants and beneficiaries.

In ruling that ERISA preempts portions of New York's Public Health Law, the Second Circuit has distended ERISA preemption to insulate ERISA plans from state laws designed to promote widespread access to affordable health insurance by controlling hospital costs simply because those laws may indirectly impact the cost to an ERISA plan of purchasing benefits. The Second Circuit's determination not only cripples New York State's efforts to grapple with the cost and financing of hospital services and the availability of health insurance, but also guts other state legislative reform efforts in this arena. As Judge Freeh acknowledged:

> Defendants correctly note that, to the extent that the Court finds that New York's statutes "relate to" employee benefits plans, then "ERISA preempts all state hospital rate-setting statutes, at least to the extent they apply to rates charged to patients that are participants in ERISA plans which include hospital expenses as a benefit." This result is obviously undesirable in that it greatly complicates states' efforts to regulate and control hospital costs.

Travelers Ins. Co. v. Cuomo, 813 F. Supp. 996, 1006 (S.D.N.Y. 1993). (A-77-78.)

In fact, as predicted by Judge Freeh, New York's healthcare system and insurance reform efforts have already begun to unravel. Relying exclusively upon *Travelers, New York State Health Maintenance Organization Conference v. Curiale*, No. 93-1298 (S.D.N.Y. Feb. 25, 1993), struck down an integral portion of New York's landmark health insurance reform. The plaintiffs in *Connecticut General Life Ins. Co. v. Cuomo*, No.

93-3648 (S.D.N.Y. filed May 27, 1993), have challenged New York's use of diagnosis related groups ("DRGs") in setting reimbursement rates on ERISA preemption grounds. And in *Capo v. HANYS*, No. 93-7996 (S.D.N.Y. filed Dec. 21, 1993), the plaintiffs filed a class action on behalf of all employee benefit plans seeking return of the over $1.5 billion attributable to payment of the 13% differential since 1988. Moreover, if the Second Circuit is correct, not only will state efforts to regulate in the healthcare arena be upset, but states will also be precluded from enacting any legislation that may have an effect on the costs to ERISA plans of purchasing goods or services.

A. Blue Cross and Blue Shield Plans in New York

The Plans comprise an unincorporated association consisting of all Blue Cross and Blue Shield Plans operating in New York State. Each is a not-for-profit health services corporation organized and existing pursuant to Article 43 of the New York Insurance Law. During 1991, Empire afforded health coverage to more than eight million persons located primarily throughout the twenty-eight counties that comprise the New York City Metropolitan, Mid-Hudson, and Northeastern areas of New York State and reimbursed hospitals $2.5 billion for inpatient hospital services rendered to persons Empire covered. The remaining Plans provided coverage to more than four million other persons throughout the rest of the State. (JA-194, 215.) The majority of the twelve million persons covered by the Plans are participants or beneficiaries of employee benefit plans governed by ERISA.

Decades ago, the Plans were incorporated with the mission to undertake efforts to issue insurance to as many people and groups as financially practical. For example, Empire's statement of corporate purpose calls for Empire to provide "the best possible coverage for the largest possible portion of the self-sustaining population on the most cost-effective basis." (JA-197.) In furtherance of this mission, the Plans sell cover-

age, including individual and Medicare supplementary coverage, on an open enrollment basis, *i.e.*, to any person without discriminating on the basis of prior illness, physical condition, age, occupation or sex. The Plans have traditionally provided this coverage at a uniform community-wide rate otherwise unavailable for high-risk individuals. (JA-198-203.) As the Second Circuit noted, "[a]s the insurer of last resort, the Blues insure persons or groups that are, on a whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers." (JA-58.)

The Plans' coverage of individuals and provision of Medicare supplemental coverage for the elderly sets them apart from commercial insurers. In almost all cases, the Plans operate at a loss with respect to the coverage of these persons. (JA-201.) By contrast, most commercial insurers do not even offer health insurance to individuals and only a few provide Medicare supplemental insurance coverage to New York's elderly.[4] (JA-201-02.)

The Plans' underwriting practices, endorsed by the New York Legislature, have greatly increased the number of insured persons in New York State with the obvious and beneficial effect of spreading costs to as many insureds as possible. In fact, New York has 20.8% fewer uninsured persons than the national average.[5] (JA-203.)

Furthermore, at any point in time, the Plans have outstanding more than $300 million in working capital advances to their member hospitals. These interest-free working funds represent a significant cost savings to hospitals. (JA-203-04.)

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[4] Even today, most of the insurance company plaintiffs in this action, such as the Travelers Insurance Company and Aetna Life Insurance Co., do not offer these coverages. (JA-202.)

[5] There is a correlation between the number of uninsured persons and whether health insurance is available on an open enrollment basis in other states. The eleven states where insurers offer open enrollment have 20% to 30% fewer uninsureds than the national average. (JA-202-03.)

The Plans have also historically engaged in a variety of other public policy initiatives including, most recently, a program to provide healthcare coverage to uninsured children in New York. (JA-204.)

B. New York State's Current Hospital Rate-Setting Scheme

New York State has adopted a comprehensive statutory scheme that regulates the insurance marketplace by controlling inpatient hospital rates. (JA-150.) To this end, the New York Legislature divided the various payors for hospital services into three categories, two of which are affected by the hospital differentials at issue here. The first consists of state government (Medicaid), Article 43 corporations such as each of the Plans (including Empire) and HMOs. *See* N.Y. Pub. Health Law § 2807-c(1)(a) (McKinney 1993). (A-101.) The second category consists of self-insured funds that pay hospitals directly, commercial insurers licensed in New York whose coverage is based on all hospital services rendered, volunteer firefighters, volunteer ambulance companies and no-fault auto insurers. *See* N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1993). (A-102-03.) A third includes "all others." Payors falling within the "all others" category include "self-pay" patients, patients covered by self-insured groups that do not make direct payments to hospitals and patients covered by commercial insurance policies that do not pay on an expense incurred basis. N.Y. Pub. Health Law § 2807-c(1)(c) (McKinney 1993). (A-103.)

Hospitals must charge the first two categories of payors strictly regulated rates based upon the DRG into which a patient falls. *See* N.Y. Pub. Health Law §§ 2807-c(1)(a)-(b) (McKinney 1993). (A-101-03.) The DRG rate is set by the State Department of Health and is based upon the cost of treating an average patient with a particular primary diagnosis. However, the rate is adjusted for each particular hospital to take into account operating costs, capital costs,

malpractice insurance, bad debt and charity care costs, primary health service program costs and physicians' excess malpractice insurance. Thus, the rate for a particular DRG will necessarily vary from hospital to hospital. And the actual cost of treating a particular patient may be more or less than the DRG to which that person is assigned. (JA-184-87, 152-53, 249-57.) Payors falling within the "all others" category pay actual hospital charges which are subject to a statutory limit. (JA-188, 154.) As such, the hospital differentials at issue need not necessarily affect any payor which falls into the class of "all others."

New York has determined that its Medicaid program, publicly financed and providing care for the poorest New Yorkers, should be in the first category of payors. To help compensate them for the burden of their community rating, open enrollment and other publicly responsible activities, HMOs[6] and Article 43 corporations such as the Plans are also in the first category. *See* N.Y. Pub. Health Law § 2807-c(1)(a). (A-101; JA-188, 153, 165-66.) Indeed, plaintiffs have acknowledged that the Plans were "granted the 13% to pay for the cost of open enrollment and community rating." (JA-207; Record; Affidavit of Jerry Weissman, sworn to September 30, 1992 ("Weissman Aff.") Exh. H.) Thus, whereas hospitals bill Article 43 corporations at the DRG rate, payors in the second category, including commercial insurers and self-insured funds that pay hospitals directly, must pay the DRG rate plus the 13% "differential." *See* N.Y. Pub. Health Law § 2807-c(1)(b). (A-102-03.)

Beginning in the late 1980s, the insurance goals promoted by the hospital cost control statute were jeopardized as a result of the commercial insurers' selection of the best risks

[6] In addition to receiving the benefit of the differential, HMOs are permitted to negotiate their payments to hospitals. N.Y. Pub. Health Law § 2807-c(2)(b)(i) (McKinney 1993). Negotiated rates have not been challenged on the basis of ERISA preemption even though they may result in more favorable treatment for HMOs.

from the Plans' community rated pools. The experience of such pools increasingly deteriorated and the community rate required to serve the relatively poorer risks that remained increased as a result. (JA-204-06, 232-33, 164-66.) Effective April 2, 1992, Section 348 of the Omnibus Revenue Act of 1992 amended N.Y. Pub. Health Law § 2807-c to require hospitals to bill commercial insurance companies subject to the DRG rate an additional 11%. 1992 N.Y. Laws, ch. 55, § 348. (A-104.) Hospitals paid the 11% differential into the State's general revenue fund. (A-105.)

The additional differential was designed to offset the competitive advantage that commercial insurers had garnered by carefully selecting the persons they would insure and by excluding persons who were ill or worked in industries which made them more likely to need healthcare services. (JA-164, 200-01, 204, 293-94.) By increasing commercial insurers' payments to hospitals, the legislature intended the 11% differential to compensate in part for the effects of risk selection by alleviating some of the significant risk differences (*i.e.*, claims costs) between the Plans and commercial insurers.[7] The resulting risk-spreading was designed to help the Plans offer affordable insurance to a broader section of the population. (JA-216-38, 164, 154-55; Record; Affidavit of Albert F. Antonini, sworn to September 25, 1992 ("Antonini Aff.") Exhs. I, N-S.) As enacted, the 11% differential was only in effect for one year. It terminated on March 31, 1993 when New York's insurance reform legislation for individuals and small groups became effective.[8]

[7] The Plans' loss of good risks to commercial insurers has virtually obliterated their community pools. In 1986, for example, Empire had a good risk to bad risk ratio of ten to one in its community pools, but by 1992, at the commencement of this action, this ratio had fallen to three to one. (JA-205.)

[8] As of April 1, 1993, new legislation went into effect requiring all insurers offering health insurance in New York to individuals and small groups to do so on a community rated and open enrollment basis. N.Y. Ins. Law § 3231 (McKinney Supp. 1994). Adjustments to rates for

Section 346 of the Omnibus Revenue Act of 1992 subjects HMOs, including those operated by the Plans, to a differential of up to 9% if they fail to enroll a targeted number of Medicaid patients.[9] N.Y. Pub. Health Law §§ 2807-c(2)(a)-(e) (McKinney 1993). (A-106-13; JA-208-09, 155, 175-77; Record; Antonini Aff. Exh. P.) Section 346 requires HMOs to pay the applicable differential into a statewide pool established by the Commissioner of Social Services of the State of New York, who then deposits this money into New York State's general revenue fund. (JA-155, 175.)

C. Legislative History of the Differentials

Unlike the legislative history of ERISA, which the Second Circuit found to be a "veritable Sargasso Sea of obfuscation," (JA-48), the history and purpose of the inpatient differential in New York is made clear by twenty-five years of legislatively authorized studies and analyses, with which the Record is replete.

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such insureds based on age, sex, health status or occupation are no longer permitted. In subsequent hospital reimbursement legislation, 1993 N.Y. Laws, ch. 731, § 35, the New York legislature retained the 13% differential, recognizing that the new legislation has not redressed all the inequities in the insurance market. First, the open enrollment and community rating legislation has not mandated that commercial insurers provide coverage in the individual market. Since commercial insurers for the most part declined to provide such coverage, the Plans continue to provide coverage to the vast majority of individual insureds in New York State. Coverage to individuals, who as a group incur significantly higher claims experience than insureds in group coverage, continues to cause the Plans significant losses. (JA-201.) Second, it will take a number of years for the new community rating legislation to balance out the risks in the individual and small group pools due to the saturation of the Plans' community rated pools with New York's highest risks. (JA-294.) Third, the Plans have continued costly public interest undertakings that commercial insurers have never undertaken such as providing over $300 million of non-interest bearing advances to hospitals. (JA-203-04.)

[9] Pursuant to recent legislation, the 9% differential was amended and extended from December 31, 1993 to December 31, 1995. 1993 N.Y Laws, ch. 731, § 35.

Over the quarter century prior to the enactment of the first statutory differential in 1983, the Plans obtained discounts or negotiated agreed-upon reimbursement rates instead of paying the hospitals' charges. The Plans generally obtained a substantial discount from the hospitals in exchange for prompt payment, cash advances and the commitment to provide coverage to individuals and groups unable to obtain insurance anywhere else in New York. (JA-218-19, 161-62.) This system benefitted both hospitals and New Yorkers by reducing the number of uninsureds in New York and providing sufficient income to hospitals. The system also benefitted the Plans by enabling them to compete with for-profit commercial insurers who failed to provide these community services. Such a policy was necessary as "Blue Cross has limitations imposed by the competitive environment in which it finds itself." (JA-219.) The market balanced these limitations by requiring commercial insurers to pay more for inpatient hospital care.

In 1965, the Governor's Committee on Hospital Costs reported on efforts to restrain costs of hospital care and to improve the quality of healthcare services. The Committee urged the Plans to continue unrestricted enrollment and other public activities. Underscoring the necessity for a differential, it noted that a system that "gravitates toward serving favorable risks, and leaves unreigned the excess cost to high users, is not meeting this social need." (JA-220-21.)

In 1969, in response to the rising costs of hospital care, New York State enacted the Hospital Cost Control Law, 1969 N.Y. Laws, ch. 957, § 2, which for the first time regulated the rates charged by the hospitals to Medicaid and the Plans.[10] (JA-180.) Commercial insurers' payments and other payors' payments were not regulated. The difference between the

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[10] Medicare rates were already regulated by the federal government by this time. In 1976, upon adoption of New York's HMO Act, Article 44 of the Public Health Law, HMOs were brought under the State's Hospital Cost Control Laws. 1976 N.Y. Laws, ch. 938, § 4.

regulated Blue Cross rates and the rates for other payors was "the differential," which ranged between 25% and 40%. (JA-222, 162.)

As hospital costs continued to rise through the 1970s, the State recognized that an effective hospital cost control system would have to regulate revenues from all payors. (JA-180-82.) The Legislature established the Council on Health Care Financing to address this issue. In 1980, after evaluating the hospital reimbursement law, the Council recommended formal legislative adoption of the differential in rates into statute, recognizing that "a prime consideration in establishing a payment differential is to reflect economic advantages or disadvantages and social considerations granted by differing operational policies and practices [of insurers] . . . on the people of New York State." (JA-223.)

In 1983, the Legislature codified the differential at a lower rate than previously used in the marketplace in a comprehensive all-payor reimbursement system known as the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"). The statutory differential was then studied by the State Hospital Review and Planning Council which issued its first report in 1985. (JA-223-24, 163.) The Council noted:

> [D]ifferentials . . . should continue to be appropriate means to enable the State to achieve certain social policy objectives, including providing hospitals with certain levels of working capital and encouraging the availability of substantial and affordable health insurance.

The Council also reiterated the historical bases for the differential: (1) prepayment to hospitals, which provides working capital and costs savings to hospitals; and (2) social policy factors such as coverage practices which make insurance available and affordable and which provide indirect financial support to hospitals by averting bad debts. (Record; Antonini Aff. Exh. E.) The Charge Differential Analysis Committee of the New York State Hospital Review and Planning Council likewise

noted in 1989 that the differentials were premised on these two key factors.[11] (Record; Antonini Aff. Exh. K.)

In 1989, the State Hospital Review and Planning Council and the Subcommittee on Insurance of the New York State Legislature's Council on Health Care Financing issued reports on the differentials. Their reports found that the differential was the Legislature's leverage for "encouraging payors and hospital providers to engage in activities which accomplish public policy objectives," (JA-229), and was a "useful vehicle to promote social policy objectives." (JA-230.) Relying upon these reports, the Legislature maintained the 13% differential in 1990 NYPHRM legislation, as well as in the present NYPHRM effective January 1, 1994.

D. Decisions of the Courts Below

By this action, plaintiffs challenged the 13%, 11% and 9% differentials as preempted by ERISA.[12] Plaintiffs moved for summary judgment requesting that the district court invalidate the differentials. The New York State defendants and intervenors—the Plans, Empire and the Hospital Association of New York State ("HANYS")—cross-moved for summary judgment dismissing the complaints. By Opinion and Order dated February 3, 1993, the Honorable Louis J. Freeh held that ERISA preempted the challenged hospital differentials as

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[11] The Council also noted that the Plans alone open enrolled all individuals without medical underwriting and subsidized insurance coverage for vulnerable groups such as the elderly. They did all this at community rates available solely because they were able to obtain sufficient numbers of healthy, low risk subscribers to subsidize the high risk claims. Significantly, the Council recommended that commercial insurers should be granted the statutory differential if they choose to fulfill these policy objectives. (Record; Antonini Aff. Exh. E.)

[12] Plaintiffs also challenged the 13% and 11% differentials on the grounds that they are preempted by FEHBA and an actuarial letter issued by the New York State Department of Insurance to regulate the issuance of stop-loss insurance contracts to self-insured plans on the grounds that it is preempted by ERISA. Neither of these issues is before this Court.

to commercial insurers and HMOs. (A-68-82.) The district court also rejected the argument that the 13% and 11% differentials fall within the scope of ERISA's "saving clause" and are, therefore, saved from preemption. (A-78-82.) By Opinion and Order dated February 9, 1993, the district court granted a stay of its Order insofar as it concerned the 13% differential.[13] (A-93-98.) The Second Circuit Court of Appeals affirmed the district court's decision that the 13%, 11% and 9% hospital differentials are preempted by ERISA and affirmed the district court's conclusion that the 13% and 11% differentials do not regulate insurance within the meaning of ERISA's saving clause. (JA-30-65.)

SUMMARY OF THE ARGUMENT

The Second Circuit erred in ruling that the challenged differentials "relate to" ERISA plans. In so concluding, the Second Circuit embraced an overly expansive view of ERISA preemption that finds no support in the prior decisions of this Court. Nor does ERISA's legislative history evidence congressional intent to preempt laws enacted within the states' police powers that were designed to control hospital costs and increase access to affordable health insurance.

Here, the challenged statutes apply generally to payors for hospital services without regard to the existence of ERISA

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[13] The district court denied a stay as to the 11% and 9% differentials except that it required plaintiffs to escrow the amounts attributable to these differentials in interest bearing accounts. (A-98.) To date, the deposits remain in the escrow accounts.

In any event, Congress amended the Internal Revenue Code to provide that employers will lose certain tax deductions relating to costs of providing health care coverage to plan participants if their plans do not pay the New York hospital differentials. The effective date of the amendment was the day before the district court's decision in this action. The amendment will expire on May 12, 1995. *See* Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13442, 107 Stat. 568, *reprinted in* 1993 U.S.C.C.A.N. (amending 26 U.S.C. § 162(n)).

plans. Many ERISA plans obtain coverage through the Plans, which benefit from the differentials; other ERISA plans obtain coverage through commercial insurers or self-funded plans, which pay the differentials. The challenged statutes, furthermore, do not dictate or restrict the choices that an ERISA plan can make regarding particular benefits provided or the manner in which such benefits are administered. At most, the challenged statutes may increase the cost of purchasing hospital services from particular insurers. However, this increase in cost does not amount to discrimination against or impermissible interference with an ERISA plan. The disparities in costs created by the differentials are no different than the disparities in costs created by numerous state laws as well as the commercial realities of doing business.

This Court should embrace the reasoning of the Third Circuit Court of Appeals in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), to uphold the challenged statutes. *United Wire* involved a challenge, almost identical to that presented here, to New Jersey's hospital rate-setting scheme. Upholding New Jersey's scheme against an ERISA preemption challenge, the Third Circuit rejected the argument that the economic impact of the challenged statutes justified a finding of preemption. Rather, the increase in costs was no different from any state regulation that increases the costs of goods and services that hospitals consume and include in the prices charged for services. *Id.* at 1193. *United Wire* further reiterated that Congress did not intend to foreclose regulation enacted under the states' police powers. *Id.* at 1196. In sum, like the differentials here, the challenged components of New Jersey's hospital rate-setting scheme were generally applicable laws which did not dictate or restrict the choices ERISA plans made in purchasing benefits and, accordingly, were not preempted. *Id.* at 1195.

In any event, the 13% and 11% differentials are saved from preemption as laws regulating insurance. Contrary to the

Second Circuit's conclusion, the differentials regulate insurance as a matter of common sense. The differentials play a dual role in both controlling hospital costs and in regulating insurance. In fact, the New York Legislature has clearly articulated that the purpose of the differentials is to affect the health insurance market in order to increase the availability of coverage and to promote practices viewed as publicly responsible by the Legislature.

In considering whether the challenged statutes are saved from preemption, the Second Circuit also erred in rigidly applying the three factors used to interpret the meaning of "business of insurance" under the McCarran-Ferguson Act. By way of contrast, ERISA's saving clause broadly applies to "any person" subject to insurance regulation—not just to core activities constituting the "business of insurance." Thus, while the McCarran-Ferguson Act criteria are instructive, none of the criteria should be viewed as determinative. Indeed, in *United States Department of the Treasury v. Fabe*, 113 S. Ct. 2202 (1993), this Court moved away from rigid application of the McCarran-Ferguson Act criteria.

Nonetheless, particularly in light of the discrete phraseology of ERISA's saving clause, the challenged statutes meet all three of the McCarran-Ferguson Act criteria. First, as found by the Second Circuit, the differentials spread risk by creating an incentive for good risks to participate in the same insurance programs as poor risks, thus spreading the costs of persons who are ill over a larger portion of the population. Second, the differentials are integral to the relationship between the insurer and the insured. The differentials have an impact on whether coverage is available and the cost of that coverage—factors which are at the core of the relationship between the insurer and the insured. Third, the differentials are key to New York's insurance industry and are directed at that industry.

Finally, the Second Circuit erred in finding that HMOs are not insurers "as a matter of law." To find that HMOs are not

insurers would ignore the monumental changes which have occurred in the health insurance marketplace and ignore that the function of HMOs is to accept the risk of providing health services for a premium payment in the same fashion as insurers. The distinction between traditional insurers and HMOs is becoming increasingly blurred as each adopts products and practices used by the other. Moreover, the New York Legislature has taken pains to specify that HMOs have only a "limited exemption" from particular insurance statutes and has explicitly subjected HMOs to most of the same regulations as insurance companies and, therefore, HMOs are "person[s]" subject to insurance regulation under ERISA's saving clause.

ARGUMENT

I.

NEW YORK STATE'S HOSPITAL RATE-SETTING AND INSURANCE REGULATORY SCHEME DOES NOT "RELATE TO" ERISA PLANS

A. Prior Decisions of this Court Do Not Support the Second Circuit's Finding that the Challenged Differentials "Relate to" ERISA Plans

Ruling that the challenged differentials "relate to" ERISA plans,[14] the Second Circuit erroneously expanded ERISA's preemption provision to insulate ERISA plans from an otherwise valid exercise of the State's police powers. In effect, the Second Circuit ruled that New York may not promote access for all New Yorkers to affordable health insurance by controlling hospital costs simply because such laws may have an indirect economic effect upon ERISA plans. The Second Circuit held that although the challenged statutes "do not refer to

[14] 29 U.S.C. § 1144(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" governed by ERISA.

ERISA plans," they nonetheless "relate to" ERISA plans within the meaning of ERISA's preemption clause because they "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand* [*Co. v. McClendon*, 498 U.S. 133 (1990)]." *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 719 (2d Cir. 1993). (JA-52.) Broadly construing and relying heavily upon *Ingersoll-Rand*, the Second Circuit found that the challenged statutes had a "connection with" ERISA plans because they increase the costs of providing hospital coverage through commercial insurers, self-funded plans and HMOs. This indirect economic impact, in turn, impermissibly impacts on plan structure and administration. *Id.* at 721. (JA-54-55.)

The Second Circuit's expansion of ERISA preemption to include generally applicable state laws designed to control hospital costs and to regulate insurance is neither consistent with the reasoning of this Court's prior decisions nor supported by ERISA's legislative history. First, this Court's decision in *Ingersoll-Rand* does not support the Second Circuit's expansive view of preemption. *Ingersoll-Rand* involved an employee's claim that he was wrongfully discharged to avoid payment of pension benefits under an ERISA plan. *Ingersoll-Rand*, 498 U.S. at 135. Finding the wrongful discharge claim preempted, this Court reasoned: "We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan." *Id.* at 139. To the contrary, "[t]he Texas cause of action *makes specific reference to*, and indeed is premised on, the existence of a pension plan. . . . Because the court's inquiry must be directed to the plan, this judicially created cause of action 'relates to' an ERISA plan." *Id.* at 140 (emphasis added).

Ingersoll-Rand neither adopted nor applied the "less stringent connection with standard" referred to by the Second Circuit. Nor has any other decision of this Court embraced such a standard. And *Ingersoll-Rand* did not even raise the issue of whether indirect economic impact upon an ERISA plan is sufficient to preempt.

Second, this Court has never found a generally applicable state statute that prescribes the amounts hospitals must charge preempted simply because that law may have an indirect and solely economic impact on ERISA plans, just like the impact on any other plans. Rather, this Court has found that a state law "relates to" employee benefit plans where the law singles out ERISA plans for special treatment,[15] where the rights or restrictions the law creates are predicated on the existence of ERISA plans,[16] where the law requires plans to provide specific benefits or dictates choices regarding plan structure, administration or reporting[17] or where the law provides an

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[15] *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (finding that Georgia garnishment statute that singled out ERISA plans for special treatment was preempted).

[16] *See District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580 (1992) (ruling that ERISA preempts a District of Columbia statute requiring employers who provide health insurance for employees to provide equivalent coverage for injured employees eligible for workers' compensation); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (holding that ERISA preempts employee's claim that he was wrongfully discharged because his employer sought to avoid making contributions to his pension fund).

[17] *See FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (finding that ERISA preempts a Pennsylvania antisubrogation statute which prevented Pennsylvania plans "from being structured in a manner requiring reimbursement in the event of recovery from a third party"); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (stating that Massachusetts statute requiring the provision of certain minimum mental health benefits "relates to" employee benefit plans); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (concluding that New York's Human Rights Law which prohibits employers from structuring their plans in a manner which discriminates on the basis of pregnancy and the Disability Benefits Law which requires the payment of specified benefits "relate to" ERISA plans); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (ruling that ERISA preempts New Jersey statute to the extent that it prevents ERISA plans from decreasing benefits by the amount of a workers compensation award).

alternative cause of action to employees to collect benefits protected by ERISA.[18]

This Court should draw a line between the type of laws found preempted by its prior decisions and the statutes here at issue. As the Second Circuit recognized, the challenged statutes do not refer to ERISA plans. (JA-52.) Nor are they predicated upon the existence of ERISA plans. Rather, the challenged differentials are ERISA neutral. They do not apply solely to ERISA plans and do not single out ERISA plans for special treatment. Many persons insured by the Plans are members of ERISA employee benefit plans; some are not. Nevertheless, in all cases the Plans obtain the benefit of the differentials. (JA-195-96.) Correspondingly, many persons covered by commercial insurance and self-insured groups are members of ERISA plans; many are not. Yet commercial insurers and self-insured funds never obtain the benefit of the differentials. New York's hospital rate-setting scheme applies generally to fees charged by hospitals to many classes of payors, including Article 43 corporations, commercial insurers and self-insured groups. The hospital charge is determined strictly by reference to the category of payor and not by whether or not an ERISA employee benefit plan happens to be the insured or whether the hospital patient is a participant or beneficiary of an ERISA plan.

The challenged statutes, furthermore, do not encroach upon Congress' efforts to ensure that state laws do not require ERISA plans to provide particular benefits or to structure or administer their plans in a particular fashion. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9, 11 (1987). New York State's hospital reimbursement scheme neither prescribes a particular method for calculating benefits nor requires that particular benefits be paid or that they be paid at a particular

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18 *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (explaining that state law claim which essentially seeks benefits denied is preempted by ERISA).

level. The differentials merely impact the amount an ERISA plan must pay for hospital services. However, differences in cost will persist hospital to hospital and state to state—with or without New York's legislative plan. This ought not be deemed to unduly interfere with national uniformity of plan administration or create the type of patch-work scheme feared by Congress.

Nor does the economic impact of the hospital differentials impermissibly interfere with the choices ERISA plans make for coverage. ERISA plans must pay for the benefits they provide to their participants and beneficiaries, and countless state laws, as well as the commercial realities of doing business in a particular area, will affect the cost of providing coverage. For example, New York has implemented regulations limiting the hours interns and residents can work and requiring experienced physicians to supervise training. The State has further required that hospital rates be increased to reflect the additional cost of State mandated staffing requirements and these increased rates affect the amounts paid by ERISA plans for hospital services. (JA-186.) Indeed, ERISA plans must take dozens of cost and non-cost factors into account when they determine which benefits to provide and how to structure their plans. And whether the cost is fixed by state laws or determined by the economic realities of a free market, all costs may influence choice of coverage. However, the amount paid for hospital care, like the amount paid for many other services, does not dictate or restrict the structure, administration or type of benefits provided by a plan. Paying for hospital care is simply one of the many costs of doing business. As with any other cost of doing business, the payor must merely pay the amount billed by the hospital.

Indeed, Congress could not have intended that ERISA plans would pay a uniform rate for a particular hospital service throughout the United States. Nor could Congress have intended that hospital charges would be calculated by a uniform methodology. In fact, no two hospitals in New York

State have the same reimbursement rate for a particular service. If two persons underwent the same surgical procedure in different hospitals in New York State, they would be billed different amounts under the DRG system, regardless of whether they were participants in an ERISA plan. And, in the absence of hospital cost control legislation, there would still be no uniformity in the amounts charged by New York State hospitals. (JA-191-92, 256-57.) Furthermore, hospital charges vary from state to state and region to region. Each state, in turn, has its own particular method for hospital payment. (JA-256.) However, such differences in costs of providing benefits do not interfere with national uniformity of plan structure and do not amount to impermissible interference with or discrimination against choices ERISA plans make in purchasing benefits.

This Court has recognized the distinction between laws that dictate choice regarding the benefits and administration of ERISA plans and those that may have only an indirect economic impact upon plans. *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 831 (1988), determined that ERISA did not preempt Georgia's general garnishment statute even though compliance with a garnishment order would impose additional administrative burdens and costs on plans. Reaching this conclusion, *Mackey* reasoned "that money judgments against ERISA welfare benefit plans . . . must be collectible in some way; garnishment is one permissible method." *Id.* at 834. Indeed, it would stretch ERISA's preemption clause beyond anything contemplated by Congress to find that ERISA plans can be excused from complying with state statutes that prescribe the amounts hospitals must bill simply because the law may indirectly affect their cost of purchasing benefits.[19] If that were the case, then all state regulations that affect the cost of purchasing goods and services used by ERISA plans would be preempted. However, ERISA plans, like any other benefit plan, must pay for hospital services, and New York State's hospital rate-setting and insurance regulatory scheme is one permissible method for determining the level of that payment.

[19] The irrational ramifications of the Second Circuit's determination can already be seen in the numerous cases challenging hospital and insurance regulations on ERISA preemption grounds. For example, the Second Circuit struck down an assessment on hospital revenues in *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994). Even further expanding upon the broad approach taken to ERISA preemption in *Travelers*, the Second Circuit in *NYSA-ILA* stated: "[T]he HFA targets only the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them." *Id.* at 827. Thus, *NYSA-ILA* can be read as stating that any law which impacts the cost of health care services is subject to preemption. Indeed, shortly after the Second Circuit rendered its decision in *NYSA-ILA*, plaintiffs in *Trustees of and the Pension, Hospitalization Benefit Plan of the Electrical Industry v. Cuomo*, No. 92-5589 (E.D.N.Y. filed Nov. 25, 1992) (an action challenging the 13% differential and New York's bad debt and charity care surcharge on ERISA preemption grounds) filed a brief with the court urging such a reading. *See supra* pp. 4-5.

Correctly interpreting this Court's prior decisions, the Third Circuit in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), recognized that laws that merely have an indirect and solely economic impact upon ERISA plans do not have a sufficient connection with ERISA plans to be preempted. In *United Wire*, the Third Circuit upheld New Jersey's hospital rate reimbursement law against an ERISA preemption challenge. Like New York's hospital rate-setting and insurance regulatory scheme, New Jersey had adopted legislation to "contain the rising costs of healthcare services, and to ensure the financial solvency of hospitals." *Id.* at 1189. Under New Jersey's hospital rate-setting system the basic rate was the DRG rate. However, the hospital bill had other components which the plaintiffs claimed were preempted by ERISA, such as a 2.2% discount granted to high volume payors and an 11% discount granted to payors with open-enrollment policies. *Id.* at 1189-90. Thus, like the plaintiffs in this action, the *United Wire* plaintiffs challenged the

"differentials" in the hospital rate charged to particular classes of payors.[20]

United Wire recognized that New Jersey's hospital reimbursement scheme does not refer to ERISA plans. *United Wire*, 995 F.2d at 1192. In contrast with *Travelers*, however, *United Wire* reasoned that:

> New Jersey's scheme may increase the charges billed to ERISA plan participants for hospital services. . . . This effect is no different in kind, however, from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs, i.e. utility costs, the wages of its employees, waste disposal costs, etc. New Jersey's scheme does not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way. Nor does it deprive ERISA plans of any alternative they would otherwise

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20 *In Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, Nos. 93-7547, 93-7573 & 93-7548, 1994 WL 513971, at *13 (3d Cir. Sept. 22, 1994), the Third Circuit, in dicta, suggested that this case may not directly conflict with *United Wire*, citing differences between New Jersey's and New York's hospital reimbursement schemes. However, the Plans and Empire respectfully submit that the *Keystone* Court misunderstands the operation of New York's hospital reimbursement scheme. The Plans received the benefit of the differentials because of their community rating, open-enrollment, and other socially responsible activities. This is directly analogous to New Jersey's granting of discounts for "quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole." *United Wire*, 995 F.2d at 1189. Furthermore, although not challenged in this action, New York's hospital rate-setting scheme also has a bad-debt and charity care component which must be paid by all payors, including the Plans. The bad-debt and charity care surcharge is currently being challenged on preemption grounds. *See Trustees of and the Pension, Hosp. Benefit Plan of the Elec. Indus. v. Cuomo*, No. 92-5589 (E.D.N.Y. filed Nov. 25, 1992). A ruling on the presently pending motions for summary judgment is expected after this Court renders its decision in this case. In any event, the Plans and Empire respectfully submit that the analysis of and test for preemption set forth in *United Wire* suffices to dispose of this action.

> have in these areas. Finally, since the cost of hospital services will necessarily vary from region to region, we fail to see how state regulation of hospital pricing like that chosen by New Jersey is likely to make interstate operation of an ERISA plan more difficult.

Id. at 1193.

The *United Wire* majority further rejected the argument that because of their fiduciary responsibilities, ERISA plans were prohibited from "paying for hospital services . . . if any portion of the price paid [could] be viewed as attributable to the cost of providing services to others." *Id.* at 1195. Using words particularly applicable to the situation here, the Third Circuit reasoned that

> there are many forms of state regulation under the police power which result in increases in the cost of doing business and corresponding increases in prices where the beneficiaries of the regulation are not those who are paying the increased prices. . . . Such regulations can significantly increase a hospital's cost of doing business and, accordingly, its billings to plan participants. We are confident, however, that ERISA was not intended to foreclose a state regulation of this kind.

Id. at 1196.

The Third Circuit also found no merit in the suggestion that the statutes should be preempted because ERISA plans' participation was required for the statute to meet its social goals. *United Wire* stated that "it is of no legal consequence if removing ERISA plans from the scene would diminish the likelihood that the statute would meet its social goals. Rather, the test for preemption in this regard is whether the existence of ERISA plans is necessary for the statute to be meaningfully applied." *Id.* at 1192 n.6.

In sum, ERISA does not preempt a

> generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out

> such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state.

Id. at 1195.

Furthermore, ten years ago, in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), the Second Circuit correctly recognized that New York State's hospital rate-setting and insurance regulatory scheme constituted a valid exercise of the State's police powers whose effect upon ERISA plans was too tenuous, remote and peripheral to be preempted.[21] In *Rebaldo*, the plaintiff trustee filed an action on behalf of a self-funded employee benefit plan arguing that ERISA preempted the predecessor to the statutes challenged in this action. *Rebaldo*, 749 F.2d at 134. Declining to find preemption, the Second Circuit rejected the argument that preemption follows because the law could increase the plan's cost of doing business. Finding that the argument "prove[d] altogether too much," *Rebaldo* reasoned:

> "That argument does not withstand scrutiny. So too, for example, do State laws and municipal ordinances regulating zoning, health, and safety increase the operational costs of ERISA trusts, but no one could seriously argue that they are preempted."

[21] In *Ingersoll-Rand*, this Court rejected the argument that the narrower language of 29 U.S.C. § 1144(c)(2), which defines the term "State" for purposes of ERISA preemption, limited preemption to state laws which purport to regulate ERISA plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 141 (1990). In *Travelers*, the Second Circuit relied upon this portion of *Ingersoll-Rand* to reject its prior decision in *Rebaldo*. (JA-51-52.) However, although a law need not purport to regulate ERISA plans to be preempted, it simply does not follow that the challenged statutes are preempted or that the remainder of *Rebaldo*'s analysis is no longer valid.

Id. at 138 (quoting *Lane v. Goren*, 743 F.2d 1337, 1340 (9th Cir. 1984)). In sum, *Rebaldo* correctly found that the laws at issue are not preempted because it

> follows as a matter of common sense from the fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514. *A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.*

Id. at 138 (emphasis added).[22]

[22] Applying the standards established by this Court, lower courts have found numerous laws of general application that may impact ERISA plans in some fashion not preempted by ERISA. *See Employee Staffing Serv., Inc. v. Aubry*, 20 F.3d 1038, 1042 (9th Cir. 1994) (finding that ERISA did not preempt a California law requiring employers to maintain a separately administered workers' compensation program and stating that "[t]he economic effect of independent state requirements on employers' incentives in drafting ERISA plans should be distinguished from the legal effect of state commands regarding ERISA plans"); *Keystone Chapter, Associated Builders and Contractors, Inc. v. Foley*, Nos. 93-7547, 93-7573 & 93-7548, 1994 WL 513971 (3d Cir. Sept. 22, 1994) (upholding Pennsylvania minimum wage law against ERISA preemption challenge); *Retirement Fund Trust v. Franchise Tax Board*, 909 F.2d 1266 (9th Cir. 1990) (concluding that California tax collection procedures were not preempted by ERISA); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987) (stating that ordinance imposing a municipal income tax was not preempted); *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984) (determining that ERISA did not preempt statute prohibiting employment discrimination); *Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn. 1994) (holding that ERISA did not preempt Minnesota's health care provider tax); *WSB Elec., Inc. v. Curry*, Nos. 90-0971 & 90-01109, 1994 WL 446039 (N.D. Cal. Aug. 11, 1994) (stating that ERISA did not preempt California statute governing wages which contractors on certain public work projects are required to pay their employees).

B. The Second Circuit Ignored ERISA's Legislative History as Well as the Strong Presumption Against Preemption For Legislation Enacted Within the States' Police Powers

Not only did the Second Circuit misapply this Court's ERISA preemption analysis, it ignored (1) the broader context of Congress' purpose in enacting ERISA and (2) the strong presumption against preemption where the challenged law was based upon the states' traditional police powers.

There is a presumption against preemption particularly where, as here, the State has enacted legislation within its traditional police powers. As explained by this Court in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981), "Our analysis of [ERISA preemption] must be guided by respect for the separate spheres of governmental authority preserved in our federalist system. . . . '[P]re-emption of state law by federal statute or regulation is not favored "in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained."' " (Quoting *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981).) Furthermore, " 'we start with the assumption that the historic police powers of the States were not to be superseded by the [federal legislation] unless that was the clear and manifest purpose of Congress.' " *Pacific Gas & Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 206 (1983) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Without question, New York State's hospital rate-setting and insurance regulatory scheme is a law enacted within the states' historic police powers. And, Congress did not express the necessary "clear and manifest purpose" of preempting state hospital rate-setting and cost control schemes. In fact, in ERISA's entire legislative history it is never even mentioned

or suggested that preemption may impact state efforts to legislate in the healthcare arena.

Congress apparently did not contemplate that ERISA's preemption clause would be construed to preclude states from enacting legislation designed to control hospital costs.[23] Representatives of state governments (other than insurance commissioners) did not play a role in the enactment of ERISA or its preemption clause. P. Butler, National Governors' Association, *Roadblock to Reform ERISA Implications for State Health Care Initiatives* 4 (1994). And since "most health policy analysts and state and federal policymakers firmly believed in 1974 that a national program was imminent[,] . . . states and other interest groups might not have seen the threat of ERISA preemption." *Id.* at 4-5. More importantly, at the time ERISA was enacted, some states had already begun setting hospital rates, yet "no one suggested that ERISA might undermine this authority." *Id.* at 5.

Congressional action in closely related matters also suggests that Congress had no intention of precluding states from enacting hospital cost control legislation. As set forth more fully in the Brief of HANYS, in legislating in the area of healthcare, in particular the Medicare and Medicaid programs, Congress has encouraged states to implement cost control systems applicable to all payors while, at the same time, recognizing that different payors could be required to pay dif-

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[23] The historical environment surrounding the enactment of a statute provides further insight into congressional intent. *United States v. Wise*, 370 U.S. 405 (1962) ("[S]tatutes are construed by the courts with reference to the circumstances existing at the time of the passage."); *Lewis v. Hegstrom*, 767 F.2d 1371, 1376 (9th Cir. 1985) ("[I]n construing a statute we are duty bound to 'consider time and circumstances surrounding the enactment as well as the object to be accomplished by it.' ") (quoting *Callejas v. McMahon*, 750 F.2d 729, 731 (9th Cir. 1984)); *Roe v. Norton*, 522 F.2d 928, 935 (2d Cir. 1975) ("A statute must be construed with reference to the circumstances existing at the time of its passage and in the light of the conditions under which Congress acted at the time.").

ferent amounts for the same services. In fact, the predecessor to the statutes challenged in this action (which included a 12%-15% differential) was enacted as part of a federally approved experiment and demonstration project adopted in connection with the federal Medicare program. *See Rebaldo v. Cuomo*, 749 F.2d 133, 136 (2d Cir. 1984).

Here, New York State has chosen to regulate hospital rates and insurance in the manner which it has determined best achieves its policy objective of increasing access to affordable health insurance by controlling hospital costs. Regardless of the wisdom or effectiveness of New York's choice, the absence of evidence that Congress clearly intended to preclude such state efforts and the need to "respect the separate spheres of governmental authority preserved in our federalist system" underscores that New York's statutory scheme must stand.

II.

IN ANY EVENT, ERISA'S "SAVING CLAUSE" EXEMPTS THE NEW YORK STATUTES FROM PREEMPTION

The strong presumption against preemption recognized in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981), applies here in regard to the State's exercise of its traditional police powers to enact a comprehensive hospital rate-setting and insurance regulatory scheme. Indeed, "[w]hen the States speak in the field of 'insurance,' they speak with the authority of a long tradition. For the regulation of 'insurance,' though within the ambit of federal power, has traditionally been under the control of the States." *SEC v. Variable Annuity Life Ins. Co. of America*, 359 U.S. 65, 68-69 (1959) (citation omitted).

Thus, to protect the states' police powers in regard to the regulation of insurance, Congress explicitly carved out laws

that regulate insurance from the scope of ERISA preemption by enacting a "saving clause" which provides:

> Except as provided in subparagraph (b), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

29 U.S.C. § 1144(b)(2)(A) (1988).[24] Due to the states' traditional powers in the field of insurance, the saving clause must be broadly construed. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741 (1985). And, in fact, preemption is "substantially qualified by [ERISA's] saving clause." *Id.* at 733. Here, as laws regulating insurance, the 11% and 13% differentials are saved from preemption.[25]

In determining whether a law is saved from preemption, this Court has looked first to "what guidance [is] available from a 'common-sense view' of the language of the saving clause." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987) (citing *Metropolitan Life Ins. Co.*, 471 U.S. at 740). Second, this Court has looked to cases interpreting the meaning of "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*; *see Pilot Life Ins. Co.*, 481 U.S. at 48. As stated in *Metropolitan Life Insurance Co.*:

> Cases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within the Act's reference to the "business of insurance"; "*first*,

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[24] Title 29 U.S.C. § 1144(b)(2)(B) (1988), the "deemer clause," limits operation of the saving clause by providing that an employee benefit plan cannot be deemed to be an insurer for purposes of any law of any state purporting to regulate insurance. This clause is not at issue here because the district court injunction against application of the differentials was issued only as to "commercial insurers and HMOs" and did not include self-insured plans. (A-89-90.)

[25] The United States has taken the position that the 9% differential is also saved from preemption as a law regulating insurance.

> whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry."

471 U.S. at 743 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)) (emphasis in original). None of these criteria alone is determinative. *Union Labor Life Ins. Co.*, 458 U.S. at 129.

These two tests, the common sense test and the McCarran-Ferguson Act factors, must be applied in a manner consistent with "the role of the saving clause in ERISA as a whole." *Pilot Life*, 481 U.S. at 51. The traditional police power to regulate insurance was reserved to the states, *Metropolitan Life Ins. Co.*, 471 U.S. at 744 n.21, and these tests must be applied to save such regulation. Despite such guidance, the Second Circuit never considered the legislative history of the differential, as developed in the Record, ignored the role of the differentials in promoting the availability of insurance in New York State and, therefore, concluded that the differentials applied only to hospital rates and not insurance—a conclusion that wars with common sense.

The Second Circuit also ruled that the differentials only meet the first of the three McCarran-Ferguson Act criteria. Although the Second Circuit found that the differentials spread risk, the Court ruled that the differentials "do not regulate any practice that is integral to the insurer-insured relationship," because they "do not directly change any of the terms, conditions or scope of coverage in commercial insurance contracts." *Travelers*, 14 F.3d at 723. (JA-59.) Again, the Second Circuit so ruled by ignoring the stated purpose of the differential—to provide access to affordable insurance—which is certainly a goal integral to the insurer-insured relationship. The Second Circuit continued to close its eyes to the

purpose of the differentials when it ruled that the differentials are not " 'limited to entities in the insurance industry,' " because they "involve entities beyond the insurance industry, including: the State, hospitals, patients, HMOs, and self-insured funds." *Id.* at 723 (quoting *Pilot Life*, 481 U.S. at 49). (JA-60.)

A. The Differentials Regulate Insurance From a Common Sense Perspective

The Second Circuit ignored the dual role that the differentials play both in controlling hospital costs and in regulating insurance in finding that the challenged statutes do not regulate insurance as a matter of common sense. It simply does not follow that because the challenged statutes regulate hospital rates, they cannot also regulate insurance in a manner that fulfills that State's policy objective of increasing the availability of affordable health insurance. The challenged differentials were directed at and designed to impact the underwriting and premiums setting practices of persons in the insurance industry. That certain insurers pay less for hospital services than other payors was part of a long term, clearly articulated legislative effort to affect the health insurance market in order to increase the availability of coverage. (Record; *see generally* Antonini Aff.) In fact, the sole factor determining the payment of the differentials is the payor's status in the insurance marketplace.

Likewise, only a conclusion-driven formalism could attribute significance to the fact that the challenged differentials are contained in the Public Health Law rather than the Insurance Law. This Court has long recognized that nothing in ERISA's saving clause "purports to distinguish between traditional and innovative insurance laws." *Metropolitan Life*, 471 U.S. at 741. Indeed, in *United States Department of the Treasury v. Fabe*, this Court ruled that a priority statute was a law regulating insurance stating that " 'mere matters of form need not detain us.' " 113 S. Ct. 2202, 2210 (1993) (quoting

SEC v. National Sec., Inc., 393 U.S. 453, 460 (1969)); *see FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (determining that an anti-subrogation law regulates insurance from a common sense perspective); *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt. Corp.*, 995 F.2d 500, 503 (4th Cir.), *cert. denied*, 114 S. Ct. 579 (1993) (finding that a state statute prohibiting "an insurer's unreasonable restriction of the insured's choice of physician and hospital" is the regulation of insurance from a common sense perspective, "albeit indirectly through the structure of the [preferred provider organization]").

B. The Second Circuit Erred in Rigidly Applying the McCarran-Ferguson Act Criteria to Determine Whether the Challenged Differentials Are Saved From Preemption

While the McCarran-Ferguson Act criteria are instructive, none of them is determinative in evaluating whether the challenged differentials are saved from preemption. ERISA's saving clause broadly applies to "any person" subject to insurance regulation. By contrast, the McCarran-Ferguson Act gives authority to the states to regulate "the business of insurance, and every person engaged therein." 15 U.S.C. § 1012(a) (1988).[26] Thus, ERISA's saving clause sweeps more broadly

[26] 15 U.S.C. § 1012 provides:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

than the McCarran-Ferguson Act and encompasses insurance regulation generally—not just core activities constituting "the business of insurance." *See Metropolitan Life*, 471 U.S. at 746, n.24 ("[T]he saving clause is broad on its face and specific in its reference."). Furthermore, in *United States Department of the Treasury v. Fabe*, 113 S. Ct. 2202 (1993), this Court moved away from strict application of the three prong test in determining whether a state preference statute applicable to an insolvent insurer regulated insurance. In *Fabe*, this Court stated that the "business of insurance" was not confined entirely to the writing of insurance contracts, but included the performance of the insurance contracts as well. *Id.* at 2209. This Court noted that in *Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), and *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982), only "ancillary activities" to the performance of a contract were at issue, that is agreements with pharmacies and peer review activities, respectively. The "ancillary activities" engaged in by the insurers did not affect the payment of claims or the cost of coverage to policyholders and, therefore, did not involve the performance of a contract and were not the "business of insurance."

In *Fabe*, this Court also remarked that the McCarran-Ferguson Act factors were applied in *Royal Drug* and *Pireno* to evaluate whether insurer conduct was exempt from federal anti-trust law. *Fabe*, however, involved the scope of the first clause of § 2(b) of the McCarran-Ferguson Act, rather than the anti-trust exemption contained in the second clause. Distinguishing between the broader language of the first clause of § 2(b) and the narrower language of the anti-trust exemption, this Court reasoned:

> The language of § 2(b) is unambiguous as the first clause commits laws "enacted . . . for the purpose of regulat-

> ing the business of insurance" to the States, while the second clause exempts only "the business of insurance" from the anti-trust laws. To equate laws "enacted . . . for the purpose of regulating the business of insurance" with the "business of insurance" itself, as petitioner urges us to do, would be to read words out of the statute. This we refuse to do.

Id. at 2209-10. That the language in the first clause of the McCarran-Ferguson Act should be read in a broader fashion than the anti-trust exemption comports with the statute's purpose. The first clause was "intended to further Congress' objective of granting the States broad regulatory authority" over insurance issues. On the other hand, the anti-trust exemption was intended by Congress "to carve out only a narrow exemption" from federal anti-trust law. *Id.* at 2210.

In the context of the ERISA saving clause, the Second Circuit erred in applying the McCarran-Ferguson Act factors as if the anti-trust exemption were at issue. Here, the differentials are not "ancillary activities" of insurers with no impact on policyholders; rather, the differentials are State designed incentives to encourage broad access to affordable insurance coverage. The language of the ERISA saving clause, like the language of the provision at issue in *Fabe*, is also broader than the anti-trust exemption under which the McCarran-Ferguson factors are generally applied. Like the first clause of § 2(b) of the McCarran-Ferguson Act, the saving clause should be read broadly to protect the states' regulatory authority over insurance, not narrowly like the limited exemption from the anti-trust law. *See Metropolitan Life Ins. Co.*, 471 U.S. at 744 n.21. As such, rigid application of the McCarran-Ferguson Act factors in this case is as inappropriate as it was in *Fabe*.

C. In the Context of ERISA's Saving Clause Language The Differentials Meet All Three of the McCarran-Ferguson Act Factors

1. The Differentials Spread Risk

The Second Circuit correctly found that the hospital differentials help spread the risk of healthcare costs over a broad section of the population. *Travelers*, 14 F.3d at 722-23. (JA-59-60.) The differentials allow insurers and HMOs to provide broad access to healthcare coverage at an affordable price by attracting good health risks into the same insurance programs as persons who are poor health risks. When more good risks participate in the same insurance programs as poor risks, the healthcare costs of persons who are ill are spread over a much larger portion of the population and coverage for all is affordable. This fits the classic definition of insurance and risk sharing. *See Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979) (citing R. Keaton, *Insurance Law* § 1.2(a) (1971)) (defining insurance as "an arrangement for transferring and distributing risk"). Without the availability of coverage, no risk transferring would occur. *See Fabe*, 113 S. Ct. at 2209; *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt. Corp.*, 995 F.2d 500 (4th Cir. 1993).

2. The Differentials Are Integral to the Insurer-Insured Relationship

The Second Circuit, however, erred in determining that the differentials "do not regulate any practice that is integral to the insurer-insured relationship." *Travelers*, 14 F.3d at 723. (JA-59.) Whether individuals can obtain coverage and the cost of that coverage are undoubtedly at the core of the relationship between the insured and the insurer, and both of these concerns are directly affected by the differentials. The differentials encourage insurer practices that lower barriers to obtaining health insurance and help ensure that persons who most need coverage can obtain it, *e.g.*, that applicants are not

denied coverage because of prior or current illness or hazardous occupation and that there is sufficient risk sharing among healthy and ill persons so that coverage is affordable.[27] Furthermore, whether the insurer engages in community rating to establish premiums affects the price of a policy as well as the rate that the premiums will increase over the years. As stated in *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969), "[c]ertainly the fixing of rates is part of [the business of insurance]." Without question, the enrollment process and cost of obtaining coverage, which determine whether the formation of an insurance relationship will occur, are as important to the insured as the items covered under the contract.

Additionally, the Second Circuit's conclusion that in order to meet the second prong of the McCarran-Ferguson Act test the regulation had to affect an actual contract term is clearly incorrect under this Court's decision in *United States Department of the Treasury v. Fabe*, 113 S. Ct. 2202, 2209 (1993). *Fabe* found a priority statute for creditors of an insolvent insurer to be integral to the relationship between the insurer and the insured because the insolvency statute ensured payment of the policyholders' claims, that is, performance of the contract. Thus, the Court focused its inquiry upon whether the statutory term affects the "relationship between the insurance company and its policyholders" and not upon whether the statute dictated any of the policy terms. *Id.* Here, the differentials do indeed affect the relationship between the insurance company and its policyholder to the extent that coverage is

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[27] As noted *supra* note 8, the fact that commercial insurers are now subject to open enrollment and community rating if they choose to enter the individual and small group market is irrelevant. In extending the differential through 1995, the New York Legislature determined that serious access problems for individuals and Medicare supplemental subscribers still remain because commercial insurers are not mandated to provide individual or small group coverage.

available and the price to be paid for such coverage is more affordable.[28]

Other circuit courts have correctly applied this McCarran-Ferguson Act factor in a broader fashion. In *Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield*, 883 F.2d 1101, 1108 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990), the court stated:

> The exemption offered to state-regulated insurance activities . . . would be thin indeed if it were deemed to cover the content of policies, but not the marketing and pricing activities which necessarily accompany these policies.

More recently, in *Stuart Circle Hospital Corp. v. Aetna Health Management Corp.*, 995 F.2d at 500, 503 (4th Cir. 1993), the court held that "treatment and cost are important components

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[28] *In Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), this Court found that Blue Shield's arrangement with certain pharmacies to charge insureds only two dollars for every prescription drug did not constitute the business of insurance under the McCarran-Ferguson Act. The Court's finding that the agreements were not integrally related to the insurer-insured relationship is clearly distinguishable from the situation presented here. The pharmacy agreements formed part of the insurers' own ordinary cost reduction efforts and were undertaken in the normal course of business. Although the differentials affect the amounts paid to hospitals, the price difference operates to prompt the Plans and HMOs to offer a fundamentally different insurance product—where traditional insurance underwriting practices are discarded and consumers' efforts to consummate the purchase of insurance contracts are rendered far easier. Open enrollment, community rating and other activities stimulated by the differential are not activities that insurers would naturally undertake if they were simply attempting to compete on the basis of price. Accepting all applicants for insurance when one's competitors do not is not a cost reduction activity undertaken in the normal course of business. In fact, open enrollment operates against the insurer's business interests. (JA-201-03, 291-92.) Therefore, unlike the business decision made in *Royal Drug*, the differentials operate as a legislative incentive to consummate the contractual relationship between the insurer and the insured.

of health insurance," and therefore are integral to the contractual relationship.

3. The Differentials Are Key to State Regulation of New York's Insurance Industry

The Second Circuit erred in determining that the differentials are not a practice limited to entities in the insurance industry. To meet this test, the practice does not have to be limited to insurers; rather, the test is whether the practice is directed at the "insurance industry." The fact that hospitals were involved in the collection of the 11% differential or are allowed to retain the 13% differential does not mean that the purpose of the challenged scheme is not insurance regulation. The Second Circuit's conclusion focused only on the differentials' role in regulating and controlling hospital rates, while ignoring the long-recognized State policy of using the differentials to attain broad access to insurance in New York.

Only those participants in the insurance industry that historically bore the burden of providing open enrollment to all persons regardless of health, age, sex or occupation, that is the Plans and the HMOs, could benefit from the 13% differential. In fact, until April 1, 1992, the statute specifically required the Plans to continue broad open enrollment policies in order to avoid losing a portion of the differential. (JA-227.) Conversely, the statute offered the incentive to commercial insurers to avoid a portion of the differential if they instituted open enrollment. None of the commercial insurers took advantage of this incentive. (JA-228.) Thereafter, the 11% differential, targeted specifically at and paid only by commercial insurance companies, was enacted to extend the regulatory effort to encourage broader enrollment policies and to help compensate for the commercial insurers' increasingly aggressive selection of good risks out of the Plans' community pools. Thus, the differentials are specifically directed at New York's health insurance industry and are central to the State's efforts to regulate that industry in a manner which promotes access to affordable health insurance coverage.

D. HMOs Which Benefit From the Differentials Are Persons Subject to Insurance Regulation

The Second Circuit erred in finding that HMOs are not insurers "as a matter of law." The Second Circuit then greatly compounded this error by concluding that, because under its view HMOs are not insurers, a law could not regulate insurance within the meaning of the saving clause if it included HMOs within its reach. The Second Circuit made such a finding on this important issue without even considering the language of the saving clause itself, which extends to "person[s]" subject to laws which "regulate[ ] insurance." 29 U.S.C. § 1144(b)(2)(A) (1988). Nor did the court address any of the substantial case law that correctly recognizes the insurance function of HMOs. The nature of the challenged differentials, the treatment of HMOs under New York law, as well as numerous decisions of lower courts demonstrate that HMOs qualify as "persons" subject to insurance regulation. And it necessarily follows that HMOs are entities in the insurance industry.

Narrowing the application of the saving clause to traditional insurers ignores the monumental changes that have occurred in the insurance marketplace. *See Fabe*, 113 S. Ct. at 2211-12; *Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau*, 701 F.2d 1276, 1286-87 (9th Cir.), *cert. denied*, 464 U.S. 822 (1983). The differences between HMOs and traditional insurers are becoming narrowed or, in fact, have been eliminated. There are many different types of HMOs and the degree to which the delivery of care by an HMO differs from traditional insurance is dependent on the type of HMO. In a staff or group model HMO, comprehensive medical benefits are offered with nominal out of pocket expenses and care is provided by physicians salaried by the HMO. If there is any meaningful distinction between an HMO and an insurer, it attaches to this model alone and only in its purest form. By contrast, almost all of the plaintiff HMOs are organized as individual practice association ("IPA") model HMOs, which contract with privately practicing physicians

who provide medical services and deliver care in their own offices. *See U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 591 (1st Cir. 1993); *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210, 1211 (3d Cir. 1993); *Health Care Plan, Inc. v. Aetna Life Ins. Co.*, 966 F.2d 738, 739 (2d Cir. 1992). However, the fact that some HMOs may deliver care (staff models) or arrange for care (IPA models) does not affect the role that HMOs play with members—they provide health-care services for a fixed fee.

In order to compete and to provide cost effective attractive products to consumers, many traditional insurers, including the Plans, have their own IPA HMOs and, in addition, offer managed care products which are identical to HMO products. On the flip side, HMOs have always covered certain services such as hospital, emergency and out of area services and are now expanding coverage outside the HMO network with new product lines. In fact, HMOs were recently given explicit statutory authority to offer coverage for what is referred to as "point of service" benefits. In other words, HMO members can now obtain covered benefits from the HMO for care rendered by providers unaffiliated with the HMO. Specifically, N.Y. Pub. Health Law § 4406(2)(a), enacted in July 1993, allows HMOs to "implement an out-of-plan benefits system that allows enrollees to use providers not participating in the plan." Thus, the difference between insurers and HMOs is "elusive" because of the movement of each to the other.[29] *See In re Estate of Medcare HMO*, 998 F.2d 436, 444 n.7, 445 n.9 (7th Cir. 1993).

In any event, when HMOs reimburse hospitals for providing services to their subscribers, all HMOs function like

[29] Recently, the Internal Revenue Service concluded that IPA model HMOs qualify as insurance companies for federal tax purposes in that the HMOs' "contracts with their members satisfy the risk shifting and risk distribution requirements for insurance." Technical Advice Memorandum, dated Dec. 17, 1993, IRS Letter Ruling Reports 9412002 (CCH).

insurers. Like the commercial insurers and the Plans, HMOs accept the risks of providing hospital care and indemnify their subscribers for such costs in exchange for a premium payment. *See* N.Y. Pub. Health Law §§ 4401(1)-(2) (McKinney 1985 & Supp. 1994).[30]

Although the Second Circuit correctly stated that HMOs do not have to be licensed as insurers in New York, N.Y. Ins. Law § 1109(a) (McKinney Supp. 1994), HMOs receive only a limited exemption from the insurance laws. In fact, N.Y. Ins. Law § 1109, entitled "Limited Exemption For Health Maintenance Organizations," states explicitly that HMOs must comply with New York's Insurance Law as required by the Public Health Law and as specifically set forth in section 1109(a). The insurance requirements include: (1) mandated benefit requirements, N.Y. Pub. Health Law § 4406 (McKinney Supp. 1994); (2) prior approval of premium rates, N.Y. Pub. Health Law § 4403(1) (McKinney 1985 & Supp. 1994); N.Y. Ins. Law § 4308 (McKinney 1985 & Supp. 1994); and (3) approval of subscriber contracts by the Superintendent of Insurance "as if it were a health insurance subscriber contract." N.Y. Pub. Health Law §§ 4402(2)(f), 4406(1) (McKinney 1985 & Supp. 1994).[31] Most significantly, HMOs

[30] N.Y. Pub. Health Law defines an HMO as an entity which "enter[s] into an arrangement [with a person or group] . . . which propose[s] to provide or offer . . . a comprehensive health services plan." N.Y. Pub. Health Law § 4401(1). A comprehensive health services plan is a plan under which a subscriber "is entitled to receive comprehensive health services in consideration for [a premium payment]." N.Y. Pub. Health Law § 4401(2). Under 10 N.Y.C.R.R. § 98.2(v), an HMO premium is defined as "the amount of money the HMO charges each enrollee for the specified benefit package."

[31] Additional regulation of HMOs as insurers under New York law includes: examinations of financial affairs by the Superintendent of Insurance, N.Y. Pub. Health Law § 4409(2) (McKinney 1985); payment of assessments for the expenses of the Insurance Department, N.Y. Ins. Law §§ 1109, 332 (McKinney 1985 & Supp. 1994); limitations on borrowing and pledging assets, N.Y. Ins. Law § 1307 (McKinney 1985); liquidation,

must engage in community rating and open enrollment and, therefore, like the Plans, obtain the benefit of the differentials. N.Y. Pub. Health Law § 4406; N.Y. Ins. Law § 4317 (McKinney Supp. 1994); 10 N.Y.C.R.R. §§ 98.2(u), 98.5(b)(18); 11 N.Y.C.R.R. § 52.42.

Case law further supports finding that HMOs function as insurers because they spread risk and cover the cost of healthcare. Recently, the Seventh Circuit stated that:

> Because HMOs spread risk—both across patients and over time for any given person—they are insurance vehicles . . . .

Anderson v. Humana, Inc., 24 F.3d 889, 892 (7th Cir. 1994).

In re Estate of Medcare HMO, 998 F.2d 436 (7th Cir. 1993), ruled that HMOs are domestic insurers under the Bankruptcy Code.[32] Although the HMOs are not required to be licensed as insurers in Illinois, in *Medcare* the court nevertheless found that because an HMO agreed to arrange for medical and hospital services in exchange for premium payments, the HMO had accepted the risk and performed an insurance function. "[T]he distinction between cash indemnification and provision of service in kind is not . . . very marked. The enrollees' healthcare costs are met . . . under either scenario." *Id.* at 444 n.7. Similarly, in *Physicians Health Plan, Inc. v. Citizens Insurance Co. of America*, 673 F. Supp. 903 (W.D. Mich. 1987), the court specifically determined that HMOs are insurers for purposes of applying the "saving clause":

> HMOs and insurance companies share the indicia of the "business of insurance." Both assume the risk that their members or insureds will require benefits in excess

rehabilitation and dissolution requirements, N.Y. Ins. Law § 1109(c) (McKinney 1985); and restrictions on investments, N.Y. Ins. Law § 1109(d) (McKinney 1985).

[32] Other courts have come to the same conclusion. *See In re Family Health Services, Inc.*, 143 B.R. 232 (C.D. Cal. 1992); *In Re Portland Metro Health, Inc.*, 15 B.R. 102 (D. Or. 1981).

> of the consideration paid. . . . In either scheme, the principle is the same: for a fixed fee, the risk and responsibility of providing benefits is shifted from a beneficiary to a third party insurer.

Id. at 907. *See Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau*, 701 F.2d 1276, 1286-87 (9th Cir. 1983) (finding that a prepaid health plan which provided pharmacy services directly to its subscribers, rather than monetary indemnification for pharmacy supplies, fell within the "business of insurance" as set forth in the McCarran-Ferguson Act even though the plan was more like a healthcare provider).

The Second Circuit's finding that HMOs are not "insurers" for ERISA purposes dangerously insulates HMOs from insurance regulation and has a significant negative impact on the states' ability to regulate the health insurance marketplace.[33] This makes no sense considering the competition between insurers and HMOs[34] and the identical healthcare benefits

[33] In fact, as a result of the Second Circuit's statement that HMOs are not insurers, HMOs have already been allowed to escape important insurance reforms on the grounds of ERISA preemption. In *New York State Health Maintenance Organization Conference v. Curiale*, No. 93-1298, transcript of hearing at 3 (S.D.N.Y. Feb. 25, 1993), the district court followed *Travelers* stating that the demographic pooling regulations, the financing mechanism for the open enrollment and community rating legislation, could not be saved because the regulations were applicable to HMOs. *Compare Health Maintenance Organization of New Jersey v. Whitman*, No. 93-5775, 1994 WL 549626 (D.N.J. Oct. 3, 1994) (following *United Wire* and upholding New Jersey's 1992 insurance reform legislation because the court was "unwilling to frustrate New Jersey's efforts to regulate healthcare costs").

[34] It is interesting to note that in *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993), U.S. Healthcare, Inc., a member of respondent New York State Health Maintenance Organization Conference attempted to define the relevant market as limited to HMOs for purposes of determining whether an exclusive dealing clause in an HMO service agreement violated the anti-trust laws. The Court of Appeals for the First Circuit declined to do so finding the relevant market to be all health care financing which includes insurers, the Blue

offered by insurers and HMOs. Moreover, it evinces a clear misunderstanding of how HMOs operate and are regulated by the states. In New York, the legislature has determined that HMOs are to be regulated as insurers in regard to some aspects of their business. The State has also recognized that it remains appropriate for HMOs to be regulated as healthcare providers for issues such as the quality of care. However, since at all times HMOs are accepting risk pursuant to the dictates of Insurance Law § 1109(a), the State has directed that HMOs are to be regulated by the Superintendent under the Insurance Law. This dual regulation also properly reflects the legislative policy behind New York's enabling legislation for HMOs, Article 44 of the Public Health Law, which was designed

> to allow HMOs to provide [healthcare] services without being hampered by the strict requirements of the State's Insurance Law; at the same time, . . . the HMO contract itself must nonetheless be regulated by the State's Insurance Department, rather than the Department of Health. (1976 Legislative Annual 240-242).

U.S. Healthca're, Inc. v. Curiale, 615 N.Y.S.2d 239, 240 (Sup. Ct. N.Y. Co. 1994) (upholding the authority of the Superintendent to regulate HMO premium rates). Regulation of HMOs in such a fashion also reflects the reality of an insurance marketplace which includes HMOs. Thus, the Second Circuit clearly erred in reaching the opposite conclusion.

Cross and Blue Shield Plans and other entities. *Id.* at 599. Similarly, in *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates*, 996 F.2d 537, 547 (2d Cir.), *cert. denied*, 115 S. Ct. 388 (1993), the Second Circuit considered the market as including "non-HMO Sources."

CONCLUSION

For all of the foregoing reasons, the decision of the Second Circuit Court of Appeals that ERISA preempts New York's differentials should be reversed.

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Respectfully submitted,

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